HealthPathWashington Advisory Team
September 18, 2012 Meeting

We are in the process of developing contract language for Strategy 2 and will engage in several activities and focus groups to continue to secure input for the project. At the HAT on September 18, 2012, we will engage in small group work to begin discussing contact requirements for three topic areas: Network Adequacy; Care Coordination; and Outreach and Education by Health Plans. We will determine a process for work group assignment; however, we would like you to review these areas and be prepared for participation in the work groups. After we complete the group work, we will provide summaries and draft documents for review across the three topics.

Group 1 – Network Adequacy

ADSA and HCA are currently analyzing data to address network adequacy. The current approach is to consider distance standards or appointment standards. However, until we secure the data, we would like the group to consider the following:

1) What are the critical topics to consider in standards for network development:

- Physical accessibility e.g. exam tables with adjustable height
- Communication access e.g. alternative modes of communication and standards for interpreter services
- Driving time and public transportation access
- Wait times for appointments (and how to categorize urgent/routine for non-medical services)
- Back-up plans for LTSS

2) Which provider types need to be spelled out in contract?

- Specialty Providers
- Medical Providers
- Behavioral Health Providers
- Long-term Services and Support Providers

4) See Table on next page for additional discussion topics (if time permits at HAT, otherwise will discuss with focus groups).

Table 1: **Tailoring Services to Meet the Needs of Medicare-Medicaid Enrollees**	
Population	**Program Strategies and Benefits**
Individuals with physical disabilities[1]	• Opportunity to self-direct services; • Individualized budgeting authority; • Facility-to-community transition services such as those provided through Money Follows the Person Demonstrations (e.g., first month's rent, security deposits, basic household necessities, and transition counseling.); • Assistance locating accessible, safe, and affordable housing; • Ability to continue relationships with existing providers; • Access to specialists and primary care providers with offices that are disability-accessible (including exam tables, equipment, and offices); and • Access to providers who have expertise and experience serving people with physical disabilities.
Individuals with communication limitations	• Availability of member materials in accessible formats, (e.g., Braille, audio, large font, compact disc, digital, reading-level appropriate, etc.); • Availability of bi-lingual materials and interpreters; • Availability of sign language interpreters to participate in appointments; • Access to assistive listening devices during appointments; and • Providing TTY and Relay telecommunication services for the deaf.
Seniors	• Access to providers knowledgeable about geriatrics; • Involvement of and training for family or community caregiver as requested; • Social and community engagement opportunities; and • Strategies and benefits for individuals with disabilities listed above.
Individuals with behavioral health needs	• Access to specialist and primary care providers knowledgeable about working with individuals with behavioral health needs; • Access to peer supports and non-traditional providers; and • Access to community integration activities such as clubhouses, social and recreational activities, and supports for independent living.
Individuals with intellectual or developmental disabilities	• Access to specialist and primary care providers knowledgeable about working with individuals with intellectual or developmental disabilities; • Access to a choice of community residential settings; • Access to a choice of day-support activities; • Availability of longer appointments if needed; and • Involvement of and training for family caregiver as requested.

Group 2 – Care Coordination

Building on input received in focus groups, how should contract language address:

- Measurable goals for care coordination:
    - Improving access to essential services (medical, behavioral health, community-based services)
    - Improving seamless transitions of care across different services
    - Improving access to preventative services
    - Improving beneficiary health outcomes
    - Improving beneficiary quality of life
- Interdisciplinary team role and members

[1] Based on information provided by Anne Cohen, MPH with Disability Health Access. http://www.disabilityhealthaccess.com/.

    - How specific should the contract be? How much flexibility should MCOs have in naming the members of the team, specific requirements for professional credentials, etc.
- Assessment:
    - Standard for completing initial health risk assessment
    - Mandatory screening questions or topics to be included
    - Comprehensive assessment to be completed within x days
    - Does every person receive a comprehensive assessment or only for those at higher risk?
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- Care Plan Development
    - Days to complete individual care plan
    - Essential elements in plan of care: goals and objectives, specific services and benefits, outcome measures, preferences for care, additional supports, strengths and family resources.
    - How often to re-assess, any specific triggers to reassess?
    - How to document enrollee participation in care plan
    - Review process, audit/monitoring by state/contractors

Group 3 – Outreach - Education and Outreach by Health Plans

- What are the most effective means to reach enrollees?
- What are the most effective means to educate providers?
- What should the plans' responsibility be vs. the state?
- How should they partner on outreach?